QUALIFYING EVENT FORM

Only about 20% of those eligible accept COBRA coverage and using an outside administrator adds 30 days to the response window for sending the qualifying event termination notices. Taking this into account, here are the steps that we recommend you follow as the employer carrier billing administrator. Paytime cannot add or delete anyone from the carrier invoice or change coverage status in any way.

Notify the carrier to terminate the coverage of the employee effective the next possible date. Usually, that will be the first of the following month. This will strongly encourage the person that wants and needs coverage to complete the required forms and send in their payment.

On or about the 10th of each month, each employer will receive an accounting for the prior month's activities including a check for all payments received for the monthly reporting period. Each employer will also receive termination notices if a QB could / should be terminated for non-payment at the end of the month. The check will be made payable to the employer and all COBRA participants that pay in a timely fashion should remain on the carriers' billing.

Please fully complete the Qualifying Event Form that follows and forward via e-mail to frank@paytimepay.com or via FAX to 804-355-7347.

The Qualifying Event Date and the Benefits Start Date are important to understand and can cause confusion with future carriers and employers if this information is not correct.

- **Qualifying Event Date –** Provide the date that the event occurred that caused COBRA coverage to be offered. The date of termination is the first date of absence due to illness or injury, etc.

- **Benefits Start Date (Original) –** This is the first date that the person was placed on the benefit plan that is covered under COBRA. Even if it is a different carrier use the original date that the person became covered under the group plan. This date is used to determine HIPAA rights for enrollment and re-enrollment at some date in the future.

QUALIFYING EVENT NOTICE

Complete this notice and FAX with cover page to 804-355-7347 within two days of the qualifying event. Please complete the entire form. Call 804.355.6674 if you have questions.

COMPANY INFORMATION

Company/Branch / Location

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Notification Completed by: ________________________ Date: __________

Employee Information		Dependant Information (if applicable)	
SSN	Gender	SSN	Gender
Last Name		Last Name	
First Name		First Name	
Middle Initial	Title	Middle Initial	Title
Address 1		Address 1	
Address 2		Address 2	
City, ST, ZIP		City, ST, ZIP	
Date of Birth		**Telephone**	
Qualifying Event Date		**Date of Birth**	
Hire Date		**Relationship to Employee**	
Telephone		**Medicaid Participant Yes / No**	
Benefits Start Date (Original)			

Qualifying Event (Please Check One)

- ❑ Termination
- ❑ Retirement
- ❑ Medicare Entitlement
- ❑ Employee's death
- ❑ Loss of Dependent Status
- ❑ Reduction of Hours Worked
- ❑ Leave of Absence / Family Medical Leave
- ❑ Divorce / Legal Separation
- ❑ Loss of Coverage

Benefit Plan	Coverage (i.e.: Family)	Monthly Premium	Last Date Covered

Received By (DPS):	**Date:**
Entered By (DPS):	**Date:**

Comments:

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HIPAA Notice: This form contains Private Health Information and any misuse, review or disclosure of the contents is strictly prohibited.